

CAMP ROCKIN' U HEALTH FORM

The information on this form is not part of the camper or staff acceptance process, but is gathered solely to assist us in identifying appropriate care. Pages 1 to 3 are to be completed and signed by the camper's parent or the adult staff member. Page 4 is to be completed and signed by your licensed physician. Please print or type all information.

CAMP ROCKIN' U
P.O. BOX 39 DOBBINS, CA 95935

PLEASE ATTACH
A RECENT WALLET-SIZED
PHOTOGRAPH.
Print your first & last name
on the back of the photograph.

REMINDERS:
Attach a copy (both sides) of your
medical/prescription insurance card
to the inside of this form.
Keep a copy of this form & let us know
if any condition changes between
examination time and arrival at camp.

ENTRY #:

CABIN:

SESSION:

NAME:

Name: _____
Last Name First Name Middle Name

Birth date: _____ Age at camp: _____ Gender: Male, Female

Home address: _____
Street Address City State Zip

Participant's telephone #: _____ Social security #: _____

NAME OF CUSTODIAL PARENT (1st person to contact): _____

Relationship: Mother, Father, Other (please describe): _____

Home phone #: _____ Work phone #: _____
(if different from participant)

Cell phone #: _____ Home or Work fax machine #: _____

Home address: _____
(if different from participant) Street Address City State Zip

Business address: _____
Street Address City State Zip

NAME OF SECOND PARENT OR GUARDIAN (2nd person to contact): _____

Relationship: Mother, Father, Other (please describe): _____

Home phone #: _____ Work phone #: _____
(if different from participant)

Cell phone #: _____ Home or Work fax machine #: _____

Home address: _____
(if different from participant) Street Address City State Zip

Business address: _____
Street Address City State Zip

NAME OF EMERGENCY CONTACT (3rd person to contact if parents are unreachable): _____

Relationship: _____ Home phone #: _____ Work phone #: _____

Home address: _____
Street Address City State Zip

MEDICAL INSURANCE COVERAGE INFORMATION: In addition to completing the section below, you are required to attach a copy (both sides) of your medical/prescription insurance card.

Name of insurance company: _____ Primary card holder: _____

Address of insurance company: _____
Street Address City State Zip

ID membership #: _____ Group # of your medical plan: _____

PERMISSION TO TREAT - SIGNATURE REQUIRED

I authorize the camp medical staff to administer over-the-counter medications and medicines prescribed for my child, including medications that my child brings to camp, those listed as medications my child is currently taking, and medications needed in the care and treatment of my child. I hereby give permission to the medical personnel selected by the camp director to administer prescribed medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be copied for trips out of camp.

SIGNATURE OF PARENT, GUARDIAN, OR STAFF MEMBER: _____

Print your name: _____ Date: _____

HEALTH HISTORY:

The following information must be completed by the parent/guardian, or adult camper or adult staff member. The intent of this information is to provide the camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form (between time of completion and arrival at camp) should be provided to the camp's health care personnel upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES:

MEDICATION ALLERGIES (list below):

DESCRIBE HOW THE REACTION IS MANAGED:

FOOD ALLERGIES (list below):

DESCRIBE HOW THE REACTION IS MANAGED:

OTHER ALLERGIES (list below):

Include insect stings, hay fever, animal dander, etc.

DESCRIBE HOW THE REACTION IS MANAGED:

MEDICATIONS BEING TAKEN:

Please list ALL medications taken routinely (including prescription drugs, non-prescription drugs, and over-the-counter meds). Be sure to bring enough medications for your entire stay at camp. Medications are to be kept in the original package/bottle that identifies the prescribing physician (if it's a prescription drug), name of medication, when the medicine is to be administered, frequency, proper dosage, and any other special instructions (ie. keep refrigerated).

- This person takes no medications on a routine basis.
- This person takes medications on a routine basis and will continue to do so during his/her stay at camp. Please identify meds below.
- This person no longer takes medications, but in the past had taken medication for hyperactivity, ADD, ADHD and/or any other complex medical condition (physical or mental)? Please identify meds below.

Name of Medication #1: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Name of Medication #2: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Name of Medication #3: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for additional medications.

RESTRICTIONS: The following restrictions apply to this individual:

- DIETARY:** Does not eat red meat Does not eat dairy Does not eat seafood Does not eat peanut butter products
 Does not eat pork Does not eat eggs Does not eat poultry Other dietary restrictions? (explain below)

Please explain any other dietary restrictions.

ACTIVITIES: Please explain any restrictions or limitations to activities, if any. The participant must acknowledge these restrictions with a signature below.

PARTICIPANT SIGNATURE REQUIRED

I understand and agree to abide by the above dietary and/or activity restrictions placed on me.

SIGNATURE OF PARTICIPANT: _____

Print your name: _____ Date: _____

GENERAL QUESTIONS: Has or does the participant:

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | YES | NO | | YES | NO |
| 1. Had any recent injury, illness or infectious disease?.. | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?..... | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (eg. knees, ankles)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (acne, itching, rash)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye wear? *..... | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea and/or constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had ear infections?..... | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed-out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 27. History of motion sickness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | 28. If yes, do you object to use of dramamine?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have an eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> | 30. Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |

*PLEASE ATTACH A COPY OF THE PRESCRIPTION

Please explain any "yes" answers given above, noting the number of the question.

IMMUNIZATION INFORMATION:

Which of the following have you had?

- Measles
- German Measles
- Mumps
- Chicken Pox
- Hepatitis A
- Hepatitis B
- Hepatitis C
- TB Mantoux test:
Date of last test: _____
Result: Positive, Negative

INDICATE ALL DATES OF IMMUNIZATIONS FOR:

<u>VACCINE</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>
DPT.....	_____	_____	_____	_____	_____
TD (tetanus/diphtheria).....	_____	_____	_____	_____	_____
Tetanus.....	_____	_____	_____	_____	_____
Polio.....	_____	_____	_____	_____	_____
MMR.....	_____	_____	_____	_____	_____
or Measles.....	_____	_____	_____	_____	_____
or Mumps.....	_____	_____	_____	_____	_____
or Rubella.....	_____	_____	_____	_____	_____
Haemophilus Influenza B.....	_____	_____	_____	_____	_____
Hepatitis B Vaccine.....	_____	_____	_____	_____	_____
Varicella (chicken pox).....	_____	_____	_____	_____	_____
MCV4 or MPSV4 (meningitis).....	_____	_____	_____	_____	_____

PHYSICIAN CONTACT INFORMATION:

Name of participant's physician: _____ Office phone #: _____

Office address: _____

Name of participant's dentist: _____ Office phone #: _____

Office address: _____

Name of participant's orthodontist: _____ Office phone #: _____

Office address: _____

SIGNATURE REQUIRED

This Health History is correct and complete. The participant herein described has permission to engage in all camp activities except as noted. Furthermore, I agree to notify the camp if the participant named above is exposed to any communicable disease within three weeks prior to camp attendance.

SIGNATURE OF PARENT, GUARDIAN, OR ADULT STAFF: _____ Date: _____

SIGNATURE REQUIRED

I agree to pay all medical charges relating to the participant. It is my understanding that local medical providers may require my credit card information (in addition to a copy of my insurance card) prior to treatment to be used for unpaid balances. I hereby authorize the physician, hospital, and/or any other medical provider, who has rendered outside medical treatment/care, to use my credit card for payment of medical charges incurred by the participant. I do not authorize the use of my credit card for any other purpose, unless otherwise indicated.

CREDIT CARD: VISA, MASTERCARD.

Name on card (print): _____ Account#: _____ Expires: _____

SIGNATURE OF CARD HOLDER: _____ Witness: _____

RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL:

I have examined this individual on (date of last examination): _____

BP _____, Weight _____, Height _____

In my opinion, the participant is or is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

Current treatment at time of this report includes: _____

Treatment to be continued at camp - see page 2: _____

Medications to be administered at camp including name, dosage, frequency – see page 2: _____

Dietary restrictions or medically prescribed meal plan – see page 2: _____

Known allergies – see page 2: _____

Description of any limitation or restriction on camp activities – page 2: _____

Please provide any additional information about the participant's behavior, and physical, emotional and/or mental health: _____

PHYSICIAN'S SIGNATURE REQUIRED

SIGNATURE OF LICENSED MEDICAL PERSONNEL: _____

Print name: _____ Title: _____

Office address: _____

Telephone #: _____ Fax #: _____ Date: _____

FOR CAMP USE ONLY - SCREENING RECORD

Dates & times screened: _____

Medications received: _____

Updates/additions to Health History noted? Yes, No, None required.

Current health needs identified: _____

Observational notes: _____

Screened by: _____